

Long Term Care Covid-19 Commission

Ministry of Health - Vision for Ontario Health
Teams
on Monday, November 16, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants
attending remotely, on the 16th day of November,
2020, 11:00 a.m. to 11:59 a.m.

1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

8

9 Amy Olmstead, Acting Executive Lead, Ontario Health

10 Teams Division

11 Allison Costello, Acting Director, Implementation

12 and Supports Branch, Ontario Health Teams Division

13

14 OBSERVERS:

15 Jillian Paul, Acting Director, Integrated Policy

16 and Planning Branch, Ontario Health Teams Division

17 Amy Leaman, Counsel to Ministry of Health and

18 Ministry of Long-Term Care

19

20 PARTICIPANTS:

21

22 Alison Drummond, Assistant Deputy Minister,

23 Long-Term Care Commission Secretariat

24 Ida Bianchi, Counsel, Long-Term Care Commission

25 Secretariat

1 John Callaghan, Counsel, Long-Term Care Commission
2 Secretariat
3 Derek Lett, Policy Director, Long-Term Care
4 Commission Secretariat
5 Jessica Franklin, Policy Lead of the Long-Term Care
6 Commission
7 Lynn Mahoney, Counsel, Long-Term Care Commission
8 Secretariat
9 Sanjay Bahal, Team Lead, Operations, Long-Term Care
10 Commission Secretariat
11 Judith Parker, Counsel, Crown Law Office, Civil
12 Roopa Mann, Ministry of the Attorney General
13

14 ALSO PRESENT:

15
16 Olivia Arnaud, Stenographer/Transcriptionist
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1 -- Upon commencing at 11:00 a.m.

2
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 So we're here. Who's leading the group? Oh, okay.
5 Ms. Olmstead. So I'm Frank Marrocco. I don't
6 think we've met before, although we seem to be
7 dragging people here from the Ministry on a regular
8 basis. But in any event, this is Commissioner
9 Dr. Jack Kitts and Commissioner Angela Coke.

10 AMY OLMSTEAD: Good morning.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 We are the Commission. There's yourself and
13 Ms. Costello. And are you expecting anyone else?

14 AMY OLMSTEAD: Yes. Also expecting our
15 colleague, Jillian Paul.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 All right. Well, we'll wait a minute, then.
18 Anyway, welcome.

19 AMY OLMSTEAD: Thank you. If you have
20 everyone at your end, we'd be pleased to start a
21 few minutes early. I will be starting with the
22 slide deck, so it would be fine if Jillian joins us
23 in a few minutes.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 All right. Well, we're all here.

1 AMY OLMSTEAD: Okay.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 So we're ready when you are. If that's fine, you
4 want to start, go right ahead.

5 AMY OLMSTEAD: Okay. Great. And does
6 it make sense, is it the most effective use of your
7 time if I go through the presentation in some
8 detail and obviously pausing for whenever you may
9 have questions?

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Yes, that's fine. Thank you. That works for us.
12 It has in the past, anyway.

13 AMY OLMSTEAD: Great. Thank you.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 We're okay with that, yes, by the way.

16 AMY OLMSTEAD: Yeah.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Yeah.

19 AMY OLMSTEAD: Great. Wonderful. And
20 thank you, Judith, for putting the presentation up
21 on this screen. I appreciate it. So I think I'm
22 going to use my own version here at this end.

23 So looking at -- so I'll just jump
24 right in. My name's Amy Olmstead, acting executive
25 lead of the Ontario Health Teams Division. Really

1 pleased to be here today to provide some background
2 on the Ontario Health Teams' initiative and answer
3 questions and talk a little bit about our
4 experience to date with respect to Ontario Health
5 Teams, and with a particular focus on long-term
6 care, obviously.

7 So I'll start with a little bit of
8 background on Ontario Health Teams and then go into
9 sort of our more recent experience.

10 So the Ontario Health Team model is
11 really based on a made-in-Ontario approach based on
12 learning that we've seen and work that we've seen
13 in other jurisdictions.

14 So obviously in the industrialized
15 world, we, governments, and populations are facing
16 similar challenges with respect to healthcare. We
17 have many providers across multiple care sectors
18 leading to potential gaps, duplication, lack of
19 coordination, and over-reliance on hospitals and an
20 under-reliance on primary care, not enough
21 attention to self-management and preventative
22 healthcare and financial incentives that are not
23 aligned and reinforce that siloed experience of the
24 health system.

25 So what we've seen in other

1 jurisdictions is a move towards integrate and
2 accountable care systems, and these systems share
3 the same features. So they share the financial and
4 clinical accountability for the quality of care and
5 for the patient and client experience and for the
6 overall costs of care.

7 The services are integrated with a
8 focus on and a foundation of primary- and
9 community-based care. The payment methods and
10 incentives are built to deliver value and not
11 simply pay for volumes of services, and there is a
12 flexible approach to that care delivery model that
13 allows for innovation and tussive change.

14 So based on the well-documented
15 experience in other jurisdictions, the Ministry
16 moved to create Ontario Health Teams.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Can I just ask, Ms. Olmstead --

19 AMY OLMSTEAD: Certainly.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 -- how did they divide up the province?

22 AMY OLMSTEAD: Mm-hm. So the Ministry,
23 and I'll ask Allison to say more about this, but
24 generally, the Ministry, recognizing what a
25 significant change this would be to move from our

1 siloed approach to healthcare to an integrated,
2 on-the-ground, partnership-based approach, the
3 Ministry made a decision to encourage local
4 partnerships and to encourage those local partners
5 in care delivery to get together and build the
6 partnership, the specific partners and client or
7 patient populations of focus that made sense for
8 them.

9 We supported those discussions with a
10 significant amount of data that would help local
11 health providers identify the services that the
12 people in their regions were using. So what were
13 those patient models? Where were they going for
14 care? How were they using care?

15 So we've encouraged those partnerships
16 to evolve locally, and that's -- where we are right
17 now is we are seeing a lot of partnerships come
18 together where, I think, around 80 percent of the
19 population is covered with these partnerships now.

20 And we continue to work with both the
21 OHTs that have been approved as well as OHTs that
22 are in development to continue to work to determine
23 how to cover the whole population and what are the
24 right partnership groupings for that.

25 Allison, can I ask you to provide any

1 additional information about how we determine this
2 approach to --

3 COMMISSIONER ANGELA COKE: I've got a
4 question.

5 AMY OLMSTEAD: -- coverage?

6 ALLISON COSTELLO: Absolutely. Good
7 morning. I'm Allison Costello. I'm the director
8 of the OHT Implementation and Supports Branch in
9 the Ministry.

10 So as Amy said, the process that we had
11 in place at the beginning was to really have teams
12 come together based on partnerships that they had
13 in place and really learn from them as we go to
14 understand what that could look like at maturity.

15 So you had sort of asked, how do we
16 divide up the province. So we started by hearing
17 from teams how they saw themselves coming together,
18 and we used a lot of data to help us understand how
19 patients currently and most recently have accessed
20 care and how those patients tend to kind of swirl
21 above a network of providers. And it's not so much
22 lines on a map, but the population that a community
23 of providers through an OHT would support that we
24 have a good sense through the data we have
25 available of how that might be organized.

1 But it's not so much lines on map, and
2 again, as we're sort of supporting teams to be
3 approved through a staged process over time, we
4 have a sense of what that will look like. We have
5 a sense through the teams that have been approved
6 right now and the networks that we have been
7 discussing with them that they'll care for over
8 time and at a more mature state and what that would
9 look like.

10 So we have a sense based on the data
11 how teams will be organized, and it's not so much
12 lines on maps but as about the populations that
13 they'll support and the providers within those
14 networks that will all be part of a partnership
15 over time.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 When they're recognized, what does that mean? When
18 they're approved?

19 AMY OLMSTEAD: Thank you. So we have a
20 phased approach for implementing Ontario Health
21 Teams, and we'll chat about that a little bit more.

22 Right now, the Ontario Health Teams
23 that are approved are ones that, we believe, have
24 met the requirements that we've set out in the
25 guidance document for Ontario Health Teams in terms

1 of the range of providers that they have included
2 in their partnership and their plans to work
3 together in the future.

4 Right now, being approved means they
5 can call themselves Ontario Health Teams, and
6 they're eligible for funding support to continue
7 their development around, for example,
8 collaborative decision-making.

9 Allison, do you want to outline in a
10 little bit more detail the stages ultimately ending
11 at designation?

12 ALLISON COSTELLO: Absolutely. So the
13 approval is a concept that we've set out within the
14 guidance document that we've released that the
15 minister will approve Ontario Health Teams based on
16 a number of criteria that we had defined that sort
17 of says they're ready to get started, they're ready
18 to begin the work, they've identified a year-one
19 population that they plan to support, but there's a
20 long way to go between that year-one population and
21 being able to support a full population with the
22 inclusion of every partner within that network and
23 every patient within that network.

24 So we had developed a staged approach
25 to assess teams' readiness to move forward with the

1 minister being the approver at the end of that
2 stage, and what's set out in the legislation is
3 that, at maturity, these teams can be designated to
4 become Ontario Health Teams, which would allow them
5 to receive an integrated funding envelope from the
6 funder of Ontario Health.

7 That is at a point in time that they
8 would be inclusive of all partners; demonstrate the
9 maturity of being able to receive an integrated
10 funding envelope. It would also demonstrate that
11 the agency itself has that maturity as well and
12 that all the partners are being cared for, in a
13 way.

14 So we had kind of set out a Stage 2,
15 approved them to begin their work, and our approval
16 of them has sort of said you're approved to begin
17 your year-one planning, and we want to be able to
18 support them and sort of put particular markers in
19 the sand to understand how their maturity is
20 progressing so that we can understand when an
21 integrated funding and an integrated accountability
22 approach will be appropriate.

23 We do see that being down the road at
24 some time based on that layer, just caring for one
25 kind of sliver of their population at this time.

1 AMY OLMSTEAD: And just to add to
2 that -- apologies. So right now, the
3 accountability and oversight and funding for the
4 partners within an OHT, and even an approved OHT,
5 it's still the previous funding arrangements and
6 oversight and accountability structure. So
7 hospitals still have all of their direct funding
8 agreements and their oversight and accountability
9 responsibilities.

10 So that is the current state. We are
11 encouraging that shared planning and then
12 encouraging the collaborative decision-making with
13 an eye at maturity to getting that more-integrated
14 accountability and funding arrangement.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Okay. Thank you. Commissioner Coke?

17 COMMISSIONER ANGELA COKE: I'm just
18 trying to understand a bit more about what would be
19 the difference between this concept and model of
20 integration versus what was envisaged with the
21 Local Health Integration Networks?

22 AMY OLMSTEAD: Hm. I would say that
23 the -- you know, certainly the LHINs and moving
24 home and community care into the LHINs was intended
25 to give the Local Health Integration Networks

1 oversight of many parts of the health system.

2 I think a difference with the Ontario
3 Health Team model is that partnership is at the
4 foundation and the shared decision-making, but I
5 wouldn't want to speculate further than that.

6 Allison, you were obviously there while
7 this was being worked out. Is there --

8 ALLISON COSTELLO: Yeah.

9 AMY OLMSTEAD: -- anything you wanted
10 to add?

11 ALLISON COSTELLO: Yeah, and I think
12 with the exception of your example, Amy, about home
13 and community care, the LHINS are administrators.
14 So the LHINS hold the accountability relationship
15 with the providers. Ontario Health Teams will be
16 the providers, the planners, the ones that provide
17 the care for their patients. They will be the
18 collective of the different health service
19 providers, together acting as one team.

20 That will still have an accountability
21 relationship with the funder overall, but the LHINS
22 were established to be planning, funding, and
23 integrating with the local health system, not the
24 providers of. So there's a step below of kind of
25 integrating the system to do and be the care

1 provider for all the population that they're
2 serving, that the LHINs, with the exception of home
3 care, didn't hold that service provision function.

4 COMMISSIONER ANGELA COKE: Okay.

5 AMY OLMSTEAD: Great. Thank you for
6 those questions. We will probably be able to add
7 some layers to our responses as we go through the
8 deck. So if we go to Slide 3 -- I'll just move to
9 Slide 3 here.

10 So to support the creation of Ontario
11 Health Teams, The People's Health Care Act received
12 royal assent, and that created the Connecting
13 Care Act, which is the supporting legislative
14 infrastructure for Ontario Health Teams.

15 So they are a new model of integrated
16 care delivery that will enable patients, families,
17 communities and providers and system leaders to
18 work together, innovate, and build on what is best
19 in Ontario's healthcare system now by tackling that
20 really key issue of integration. So the goal is
21 for the groups of healthcare providers to work
22 together as a team to deliver the full continuum of
23 care for patients in a coordinated way.

24 And they will have common -- they'll be
25 working to achieve common goals related to improved

1 health outcomes, improved patient and provider
2 experience, and, of course, value for money, value
3 for the funding that we're investing in our health
4 system.

5 So as we talked about, the current
6 funding and accountability mechanisms will remain
7 in place in the near term. OHTs, as we've talked
8 about, they've come together as a network of
9 partners. They're doing a lot of planning, and
10 they're starting to create collaborative
11 decision-making models, but they are not at a level
12 of -- a place of maturity where they have shared
13 accountability for the services that the network of
14 partners provides.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Can I just ask: We've heard that in Wave 1,
17 dealing with long-term care facilities, there was a
18 shortage of trained staff trained in the use of
19 personal protective equipment and so on.

20 Am I right in understanding that the
21 Ontario Health Teams at this stage of their
22 development, it's a bit early for them to be
23 involving the different partners in filling those
24 needs? Am I right or not?

25 AMY OLMSTEAD: They were not

1 accountable or required to do so as part of where
2 they are in their development, but what we did see
3 and what we're happy to speak to in a couple of
4 slides is that OHTs were using the partnerships and
5 relationships that they had started to develop to
6 support their network partners. So we did see that
7 happening as a result of their work to date as
8 OHTs.

9 But to your point, no, they didn't have
10 a new accountability necessarily to do so, to help
11 or to provide resources to their partners, but we
12 did see them -- we did see examples of where that
13 was happening.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 So when you say a new accountability, you mean they
16 weren't mandated to do it?

17 AMY OLMSTEAD: As part of the -- right.
18 As part of their OHT status at this point and the
19 accountabilities or what it means to be an OHT
20 right now, that's correct. They weren't required
21 to step in and devote resources to one of their
22 system partners, but we did see them do that as a
23 result of the relationships they've built.

24 And, of course, there were also, then,
25 ministry mechanisms or government mechanisms where

1 we were supporting the cross-deployment of
2 resources as well.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay.

5 COMMISSIONER JACK KITTS: Just to
6 clarify: So I think what you're saying is that a
7 hospital, the primary care physicians, the home and
8 community care, all of the partners in an OHT
9 ultimately are accountable still to their boards
10 and their governing bodies, and they're responsible
11 to deliver the mandate that they've been given as
12 individual silos.

13 But getting together for the past year
14 or two did create relationships that, while not
15 mandatory or mandated, did lead to integrative
16 activities because of existing relationships and,
17 in those cases, worked very well.

18 And right now, what I think you're
19 saying is that at a certain level of maturity, the
20 Ontario Health Team will work as a unit with a
21 governing body, a funding envelope, and a
22 responsibility to look after a population as
23 opposed to their own individual mandate; is that
24 where this is going?

25 AMY OLMSTEAD: Yes. That is exactly

1 correct. Thank you for saying it so clearly.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Yeah, Commissioner Coke?

4 COMMISSIONER ANGELA COKE: So I just
5 want to understand: In the current state now, once
6 the OHTs are set up, who oversees them now?

7 AMY OLMSTEAD: In the current states,
8 the various partners within an OHT are overseen by
9 their existing accountability relationships, so
10 that may be to the LHIN; that may be directly with
11 the Ministry. It would depend on the particular
12 partner.

13 COMMISSIONER ANGELA COKE: Okay. But
14 the OHTs, they're getting some additional funding
15 as an entity --

16 AMY OLMSTEAD: Yes.

17 COMMISSIONER ANGELA COKE: -- and the
18 overseeing of that. I understand the individual
19 partners have their straight-line accountability,
20 but right now, you have an entity; you are giving
21 it money; there is some sort of agreement that's in
22 place that has to be followed.

23 So I'm just trying to understand: Who
24 is overseeing that coordinated entity?

25 AMY OLMSTEAD: Great. Thank you for

1 clarifying. So the funding arrangements are not
2 yet in place. We expect that they will happening
3 soon, and that will be a funding agreement between
4 the Ministry and the OHT or the partner within the
5 OHT responsible for holding the funding. So the
6 Ministry will have that accountability relationship
7 for the deliverables related to that particular
8 funding envelope, and that funding is really
9 intended to support the development of the OHT as
10 opposed to service delivery.

11 Allison, you've been working on those
12 agreements. Is there anything that we should add
13 there that would be helpful to this answer?

14 ALLISON COSTELLO: I think you covered
15 it, Amy, and there are some slides that speak to it
16 a little bit later. It is about the teams that
17 have come together for and established a
18 collaborative decision-making arrangement process.

19 So the funding is related to their work
20 together but does not replace their existing
21 accountability structures. It is about the work
22 that they're undertaking as a collective and how
23 that funding can support them and related to their
24 progress as an OHT and what they'll achieve
25 together, the reporting that they would make to the

1 Ministry based on that.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Do I understand that the decision-making, that the
4 Ontario Health Team decision-making model is
5 collaborative? So what do they do? Would they
6 take a vote? I mean, is it binding on the members?

7 So if the team takes a decision that
8 requires a long-term care facility to do something,
9 is that binding on the long-term care facility, or
10 can they say "No, we don't think so"? How do they
11 impose their -- how does that work?

12 AMY OLMSTEAD: So I'm going to ask
13 Allison or Jillian to provide some additional
14 information about that.

15 I will say, off the top, that what the
16 particular governance structure will look like,
17 that collaborative governance is still something
18 that we are working through. I think it represents
19 the peak maturity of the model to be able to engage
20 in that kind of meaningful collaborative
21 decision-making that does, you know, bind or have
22 an impact on all partners.

23 ALLISON COSTELLO: And I can start
24 certainly on that point. We, in the summer,
25 released some guidance for collaborative

1 decision-making arrangements that we hoped would be
2 helpful to teams to understand what we hoped that
3 they'll put in place and what we would expect to
4 see in place reflecting their current state of
5 coming together, which is, as you said it,
6 Commissioner, early stages, and sort of reflects
7 that they're coming together to make decisions that
8 are in support of their year-one objectives,
9 reflecting how they will distribute the
10 implementation funding the Ministry is giving to
11 them.

12 They will be decisions that are sort of
13 in the realm of that -- thank you, Judith --
14 related to kind of what we think they should have
15 in place as far as their structures, the inclusion
16 of different representative groups across it, and
17 ask teams to make those decision-making
18 arrangements, you know, including that list that
19 you'll see there on Slide 14, but that it is not --
20 we have not sort of said this is the terms of
21 reference; these are the legal documents you have
22 to follow; this is how we think you should include
23 your board representation or what you need to clear
24 with your board, each provider, as you undertake
25 this. Each provider is determining how they're

1 coming to the table and attesting to this
2 relationship that we're asking them to make.

3 So it is very unlikely that it would be
4 to the level of decisions that would alter
5 accountability arrangements that they already have
6 in place, as it is kind of reflecting their early
7 stages of implementation.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 The reason I was asking the question -- and I'm
10 sorry for belabouring this, but I'm having some
11 difficulty. You know, we're dealing with an
12 emergent -- we're dealing with looking back at
13 Wave 1 and, I think related to that, trying to
14 figure out whether Wave 2 is going to look any
15 different than Wave 1.

16 And so we're dealing with a situation,
17 I think, that you could fairly call an emergency,
18 and I was trying to understand how direction is
19 given in a situation like that. But it sounds like
20 maybe that's for a time later on when the health
21 team has matured more; it's a bit premature to ask
22 that question now.

23 AMY OLMSTEAD: I think that's an
24 accurate assessment that the -- our actual
25 expectations of OHTs at this time would not include

1 binding collaborative decision-making. So that's
2 not a tool that we had in the first wave, and it's
3 not a tool that we will have in the second wave
4 with respect to accountabilities and resource
5 allocation related to COVID, for example.

6 It's a learning that we are actively
7 engaged in as we think about OHTs at maturity, for
8 sure. We think that the experience during COVID
9 has pointed to the value of this type of locally
10 driven collaborative partnership model, but we do
11 recognize and you all recognize with your questions
12 that we are a distance away from that. But that is
13 the path that we are working on.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Right. And I think you're -- I mean, I think a
16 person could easily come to the conclusion that
17 locally driven decisions are going to be better and
18 more nimble than a centralized decision-making
19 structure, especially in an emergency.

20 AMY OLMSTEAD: Well, and I think it
21 speaks to the variable -- how the health services
22 have evolved over time in different parts of the
23 province and the variable impact of the emergency
24 but also the variable capacity.

25 In some communities, you might have a

1 hospital that has a different capacity or primary
2 care that has a different capacity than in others,
3 so it speaks to where do we have the strength of
4 resources in order to be able to assist Partner X
5 or Partner Y, which I think is another -- as you
6 say, it speaks to the power of a local model.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Okay. Commissioner Coke?

9 COMMISSIONER ANGELA COKE: Just a few
10 things for clarification: So provider
11 participation in a team is voluntary?

12 AMY OLMSTEAD: At this stage of
13 development, yes, we are asking willing partners to
14 come together.

15 COMMISSIONER ANGELA COKE: Okay. So a
16 long-term care home could say "Yay, I'm in" or "I'm
17 not interested"?

18 AMY OLMSTEAD: At this time, it is
19 voluntary. The end-state vision of Ontario Health
20 Teams is the full continuum of care, including
21 long-term care.

22 COMMISSIONER ANGELA COKE: Okay. And
23 just in terms of public health units, are they in
24 the scope and mix of this?

25 AMY OLMSTEAD: It's anticipated that

1 Public Health, like all other health providers,
2 will be part of the OHTs at maturity as well.

3 COMMISSIONER ANGELA COKE: Are there
4 any that have been involved in the ones that have
5 been developed to date?

6 COMMISSIONER JACK KITTS: I can answer
7 that. Allison, I think you probably can too.

8 Yes, in Ottawa, one of the -- the local
9 Ontario Health Team which I was involved with for a
10 couple of years does have Public Health present.

11 COMMISSIONER ANGELA COKE: Thanks.

12 AMY OLMSTEAD: And Judith has kindly
13 put on the screen the list of Ontario Health Teams
14 who already have long-term care partners.

15 ALLISON COSTELLO: And I might just add
16 a caveat to that page before you jump off it,
17 Judith, is that that was based on the full
18 applications and the partners at that point, and we
19 do know from our conversations with some of the
20 teams that are not listed here that they do have
21 LTC participating in some way now. So we do think
22 that it has increased over the past year.

23 COMMISSIONER ANGELA COKE: Great.

24 JILLIAN PAUL: I would say the same for
25 Public Health as well.

1 ALLISON COSTELLO: Yeah.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Well, I think we've stopped asking questions, so go
4 ahead.

5 AMY OLMSTEAD: All right. We'll go
6 back to the slide deck, and I think we can go
7 through a couple of slides quite quickly because
8 you all clearly understand the goal of an OHT and
9 the value of having that full, coordinated
10 continuum of care that we've talked about in order
11 to promote the most effective use of the health
12 system resources and promote health outcomes and
13 patient and family experience, particularly
14 regarding transitions during their care journey.

15 And we've talked about, at maturity,
16 having a single clear accountability framework with
17 an integrated funding envelope. So very much
18 focused on the quadruple aim.

19 So if we go to Slide 5, a little bit of
20 an illustration here in terms of how we've asked
21 the Ontario Health Teams as they plan to think
22 about how to expand and deepen their work, and what
23 we've asked them to do is to identify year-one
24 priority populations as a starting point.

25 And we saw some variation in terms of

1 the year-one priority populations, which is to be
2 expected, and again, that's around really
3 leveraging the local knowledge about where the
4 greatest impact could be felt with a focus on a
5 particular population, or, in some cases, they may
6 be building on strengths that they already have in
7 a particular area or within a particular network,
8 and they want to really leverage that for their
9 planning to obviously support their entire patient
10 and client population at maturity.

11 COMMISSIONER ANGELA COKE: So, sorry.
12 I have --

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Commissioner Coke, you have a question?

15 COMMISSIONER ANGELA COKE: -- a
16 question. Mm-hm. Just in terms of -- I mean, I'm
17 just trying to understand this in sort of practical
18 terms. When we talk about, you know, better
19 connect the care, who in your model, who is the one
20 [indecipherable] integrator for the patient as they
21 move through whatever continuum of care that you
22 have in place?

23 AMY OLMSTEAD: Well, we certainly want
24 to encourage a no-wrong-door approach, and the
25 integrator, we think, will vary based on the client

1 or patient population.

2 So there may be -- we certainly want to
3 encourage primary care as an integrator. When I
4 think of home and community care, which is also in
5 our division, the linkages between home and
6 community care and primary care is a very powerful
7 partnership.

8 We see a model where, you know,
9 Mrs. Kumar has been going to her family doctor, her
10 primary care provider for a number of years, and
11 she's reached the point where she needs additional
12 supports at home, that, you know, the model where
13 someone within that primary care practice is able
14 to then connect her with home care and have that
15 home care overseen by that primary care practice.

16 So that would be one type of model of
17 integration, but certainly, our expectation on
18 Ontario Health Teams is that there would be
19 improved transitions for Mrs. Kumar when she goes
20 to hospital, if she goes to hospital, and then
21 comes out, that it's not that siloed experience.

22 So one of the challenges we've given
23 OHTs is to think through and test models to improve
24 that integration through the care journey.

25 All right. If we look at the next

1 slide, 6: So we've spoken a fair bit about this in
2 terms of the collaborative decision-making
3 structures, expectations regarding shared clinical
4 pathways, unified strategic plans and integrated
5 quality improvements, planning our key components
6 of an OHT.

7 We also are really emphasizing patient
8 and family engagement. We know that's important
9 for all parts of the care experience but certainly
10 as OHTs are underway in planning new models and
11 developing them, that engagement with patients and
12 families will be really critical.

13 So I think we've addressed the other
14 parts of that slide, so I think I'm going to hand
15 things over to Allison to walk through the -- give
16 a snapshot or sort of a status update in terms of
17 where we are with OHTs and long-term care.

18 ALLISON COSTELLO: Thanks, Amy. So on
19 the slide you see here, we've just sort of
20 emphasized some points related to long-term care
21 within OHTs, and as we've noted in the appendix, we
22 do have a list of OHTs that are approved that have
23 LTC partners, and we are quite confident that the
24 number actually has grown, and we are looking to
25 capture the more current-state picture of all of

1 the partners across all of the OHTs.

2 And we have been working very closely
3 in trying to emphasize the inclusion of LTC within
4 Ontario Health teams as they come together, and we
5 know that there is a lot of benefit that groups
6 have seen to LTC being part of the participation,
7 especially from early days. If you get in at the
8 early stages, you'll definitely see a broader
9 opportunity for partnership.

10 You know, we know that there are
11 barriers to participation across many sectors that
12 people have identified, and we are looking to kind
13 of understand more about those so we can support
14 their removal and support increased participation.

15 So we'll be increasingly working with
16 our Ministry of Long-Term Care colleagues to
17 identify those opportunities to support increasing
18 their participation and work more to see how we can
19 advance that. And I think hearing some stories
20 about what has happened through COVID and what
21 benefits have been extended will help with that
22 along the way.

23 So on the next slide --

24 COMMISSIONER ANGELA COKE: Can I just
25 ask a question?

1 ALLISON COSTELLO: Yes.

2 COMMISSIONER ANGELA COKE: You
3 mentioned some teams have noted the systemic
4 barriers to change that exists within long-term
5 care. Do you have some examples of that?

6 ALLISON COSTELLO: For sure. And I
7 don't know, Amy, if you wanted to start, or...?

8 AMY OLMSTEAD: Yeah. I think when we
9 think about -- you know, we phrased it that way
10 because we were looking at this -- this slide is
11 focused on long-term care, but the barriers that
12 long-term care or that any partners in any sector
13 would face or see or be considering when they're
14 looking at OHTs I think are quite similar.

15 Its legacy issues with respect to
16 historical funding arrangements, separate
17 accountability arrangements, a lack of a
18 relationship sort of on the ground today would be
19 some of the barriers that we see when we hear, you
20 know, anecdotally from partners what they're
21 considering. Yeah.

22 Allison, was there anything else on
23 that? I think -- I mean, I think the questions
24 would be -- you know, we hear things anecdotally,
25 and they tend to be related to those issues, yeah.

1 COMMISSIONER ANGELA COKE: Mm-hm.

2 ALLISON COSTELLO: And I would say, you
3 know, those that have partnered in cross-sectoral
4 usually -- you know, specific pathway endeavours
5 and seeing the benefit of that will see that the
6 benefit outweighs the barriers and look to pursue
7 more participation.

8 But where there haven't been as many
9 partnerships or as many cross-sectoral
10 interventions that people have tried before,
11 they're not aware of what the benefit that could be
12 extended to them is. So it's going to be a lot
13 about knowledge translation and sharing information
14 about what could be available to teams if they join
15 in. All --

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 So let me just ask --

18 ALLISON COSTELLO: Yeah.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Excuse me. Just let me ask: Is the idea that the
21 Local Health Integration Network will hold the
22 teams accountable for what they've said they're
23 going to do on a kind of practical basis, or is
24 somebody else going to do that?

25 AMY OLMSTEAD: So at maturity, Ontario

1 Health will hold the funding for Ontario Health
2 Teams and have that accountability relationship.

3 Currently, the Local Health Integration
4 Networks continue to hold accountability agreements
5 with many partners in the system. The government
6 has indicated that, over time, the plan is to phase
7 out the LHINs with their responsibilities
8 transitioned to Ontario Health and some of their
9 responsibilities transitioned to Ontario Health
10 Teams. That will be a gradual process.

11 So it's obviously a theme in our
12 discussion today in terms of the careful and
13 planned and gradual transition to this model, and
14 with respect to the role of LHINs, that's also
15 underscored by the importance of continuity of care
16 delivery, not just for home and community care and
17 long-term care home placement which LHINs are
18 responsible for delivering, and not just funding
19 but for all aspects of the system that they would
20 have oversight of.

21 But the end state, as I say, would be
22 for Ontario Health to have that accountability
23 relationship with Ontario Health Teams.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Okay.

1 ALLISON COSTELLO: So I'll move on to
2 Slide 8. This is an overview of our work-to-date
3 to establish Ontario Health Teams from the
4 Ministry's perspective, and the concept of Ontario
5 Health Teams was introduced in the legislation in
6 February of 2019.

7 And we've kind of put some more meat on
8 the bones of what that concept was through guidance
9 we released that spring and opened up a staged
10 process for approving OHTs, with an initial call
11 for self-assessments in the spring of 2019 with
12 over 150 different groups coming together at that
13 point to indicate their interest in participating.

14 Based on that, we invited 30 teams to
15 complete a full application and conducted a review
16 of those applications over the fall, and then now
17 it's the first 24 approved Ontario Health Teams in
18 the winter.

19 We have been supporting teams that were
20 otherwise -- you know, other teams that came
21 through the 150 applicant groups, trying to
22 understand kind of how to support them to achieve
23 approval over time as well, which, in a lot of
24 cases meant the eventual track for all 150 of those
25 submissions was not to reach approval. There will

1 not be 150 teams; a lot of those applications
2 didn't quite match the model.

3 But a number of them did, and we've
4 been trying to work with all of those teams to
5 support them, to achieve alignment with what we've
6 set out and understand how to support their
7 readiness. So that included progress reports from
8 a number of teams in the fall to support another
9 invitation to complete full applications that we
10 were on track to do in the spring.

11 But we put a number of our OHT
12 activities on pause in March and communicated to
13 all teams that we were putting those things on
14 pause to allow them to focus on COVID response and
15 kind of turned "go" again in July, but we did reach
16 out, and the next few slides will speak to that.

17 We reached out to every team in June
18 and July to understand where they were as far as
19 their implementation, understand what their COVID
20 response had looked like, and also make sure that
21 we heard from them what their capacity was to
22 restart OHT activities.

23 And based on that, we did announce in
24 July more teams that we were inviting to full
25 application. We also announced approval of five

1 more teams that were from the first round of
2 applications, and we announced that funding was
3 available for approved teams that completed their
4 collaborative decision-making attestation.

5 And we had a webinar in August that
6 spoke to a lot more detail about each of those
7 aspects, and we're hopeful to have an announcement
8 shortly based on the review of the most recently
9 submitted applications to the Ministry.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 And how many health teams do you anticipate there
12 will be in the province?

13 ALLISON COSTELLO: We have not set a
14 number distinctly, as we think it really will
15 relate to how teams come together. We do have a
16 sense of how many networks the data shows us, but
17 we know that the teams may come together in
18 different ways.

19 We know we've got 29 approved teams
20 right now. We had 17 applications. So each of
21 those 29 plus 17 reflected teams that were really
22 aligned to what the data showed us as far as how
23 they plan to care for a population at maturity, and
24 beyond that, there are a number of teams that are
25 not quite aligned, so a number of teams where there

1 might be three teams or three proposed teams within
2 a network that shows us that it is one common
3 population.

4 And we're trying to understand what the
5 openness is of those teams coming together to
6 support a coordinated approach for that population,
7 and how that next phase of teams comes together
8 will really help us determine what that end-state
9 number is. So we have a vague sense but not a
10 concrete one.

11 COMMISSIONER ANGELA COKE: Just to add
12 on that, do you have any sort of preferred or
13 desired time frame by which you would like this to
14 be sort of the pervasive model across the province?

15 ALLISON COSTELLO: I would say we have
16 not -- we have additionally not set a time by which
17 all OHTs will reach their maturity, but we are very
18 much -- and the minister announced in her
19 announcement in July, in her participation in that
20 August webinar, the ability to have some approved
21 OHT activity in every network of the province based
22 on this data is quite within reach.

23 We do have a sense that there is kind
24 of activity in every area that we can support
25 progression on. So we're trying to focus our

1 energy to support having an approved OHT within
2 every network in the next few years, but again,
3 those would be doing that preliminary work for an
4 initial year-one population, not a fully mature
5 population.

6 COMMISSIONER JACK KITTS: Allison, I
7 think you've explained why these are so important,
8 and I think the pandemic has put an exclamation
9 mark on why healthcare providers must work together
10 in the best interests of population. So nobody
11 asks why we need OHTs, I don't think, anymore.

12 What they're trying to achieve is the
13 quadruple aim, which I don't think there's any
14 health system in the world that wouldn't agree that
15 those are exactly what we need to do.

16 It seems that how to get there is where
17 we're tripping over each other, and I understand
18 that the initial was, here, we're going to create
19 Ontario Health Teams; you show us how to create
20 them in your local area because it really is all
21 about relationships.

22 So my question is, if we're going to
23 accelerate the development of them across the
24 province, do you have any models right now that
25 aspiring teams or developing teams or early teams

1 could learn from in terms of what worked, and with
2 the pandemic, certainly would have given a good
3 opportunity to see how a team worked? Do you have
4 any that you can point to in the province for
5 others to aspire to?

6 ALLISON COSTELLO: I think you've heard
7 from some of them. Looking at the past
8 transcriptions, we're very much -- we don't have
9 that kind of common sense of reporting from every
10 OHT to know the level of kind of their
11 sophistication or what we've heard from -- or what
12 they've been able to achieve through the pandemic.

13 We're working to build that, and we
14 very much want to gain on the learning from teams
15 that are really having successes in a number of
16 domains. So there are a lot of, you know, LTC
17 integration and support to LTC through COVID as one
18 aspect, how people have supported better access to
19 primary care to support their teams, virtual and
20 other aspects that we want to set up the learning
21 and really create that collaborative and knowledge
22 translation and mentor-mentee and champions across
23 all of these aspects to really support this was --
24 this worked. Everyone can learn from it, and then
25 if it worked and everybody can learn from it, what

1 then about that that we might want to standardize
2 or put in place as a given.

3 And we're still in that learning stages
4 of trying to find out from teams about how they've
5 been able to advance their work.

6 COMMISSIONER JACK KITTS: Well, we've
7 heard from hospitals and public health and
8 long-term care how those three came together to
9 deal with crises in long-term care. I believe
10 we've heard from Robert Garron, is it, the
11 hospital?

12 ALLISON COSTELLO: Michael Garron,
13 yeah.

14 COMMISSIONER JACK KITTS: Michael
15 Garron.

16 ALLISON COSTELLO: Yeah.

17 COMMISSIONER JACK KITTS: And I think
18 the CEO of the hospital there indicated that it was
19 an Ontario Health Team that did that work.

20 But you have 29 identified Ontario
21 Health Teams. Do you have more from those approved
22 Ontario Health Teams that could be examples for
23 others?

24 ALLISON COSTELLO: Maybe I --

25 AMY OLMSTEAD: Is it okay if I --

1 ALLISON COSTELLO: Maybe I can go to
2 the next slide to speak to that because we
3 absolutely do. And when we had had an outreach to
4 the teams between June and July to kind of
5 understand what restarting our OHT activity would
6 look like, we really didn't want to be in the way,
7 pulling attention inappropriately from the work
8 they needed to do locally.

9 So we had heard from a lot of them, a
10 pretty resounding response to not slow down our OHT
11 work because it has supported the collaborative
12 cross-sectoral effects to supportive pandemic
13 response.

14 So we do have on this slide a number of
15 examples of LTC being well supported through OHTs'
16 activities, which is sometimes hospital-led,
17 sometimes public health but sometimes primary care,
18 or otherwise community partners being part of a
19 broader collaborative, and the commitment that the
20 Ministry has made to learn from those that are
21 implementing first to really inform what to do
22 next.

23 And certainly, we didn't anticipate it
24 would be a pandemic that we would be learning from,
25 but it has spurred a tonne of learning for us that

1 we want to really take hold and move to spread
2 across OHTs, especially in those areas where
3 they're most in need based on transmission rates
4 and the like.

5 So this slide sets out certainly a lot
6 of what you would have heard about IPAC advice to
7 LTC volunteer emergency responses to support LTCs
8 in need; tables that really are in place to
9 strengthen the relationships across sectors;
10 evacuation plans to support rapid and safe transfer
11 of patients across homes; PPE distribution and
12 acquisition across partner groups, including LTC;
13 and critical staffing needs, that they could be
14 supported across the broad-sector participation;
15 and also virtual care being an enabling element of
16 all of that.

17 So these are a sampling of the stories
18 that we heard from the teams when we reached out in
19 June and July from that, but really turning that
20 into a learning system across all OHTs, across the
21 29 approved right now, and those that would be
22 approved going forward. But also those that are
23 not yet approved, there's a tonne of learning here
24 as people are building together their preliminary
25 work on an OHT table that we really do want to

1 support the learning across and best practices that
2 should be in place.

3 The next few slides speak to more of
4 the same, but I can definitely whiz through them
5 quickly for any further questions we have.

6 But really, aligned with the message of
7 wanting to learn from the implementation of OHTs to
8 support what to do next, from the Ministry's
9 perspective, from supporting OHTs, from building
10 the agencies' response as well, as they're a key
11 partner -- Ontario Health is a key partner in
12 supporting OHTs as well.

13 So in addition to the calls that we
14 took in June and July, we also have a number of
15 support partners that are capturing information
16 from OHTs, including evaluation partners that have
17 been doing specific exploration of learnings
18 through COVID across these teams. So we're
19 highlighting a number of those as well.

20 So cross-provider partnerships that
21 have really enabled a strong sectoral response, and
22 I think one of the questions we heard earlier was
23 about how nimble a response can be. And we
24 definitely heard that the ability of these teams to
25 move quickly when a problem came up and just have

1 everybody at the table and do it is really what we
2 heard was in place across these structures.

3 We know that the regional tables across
4 OH really supported coordination as well and some
5 learnings as they were going. So if that was about
6 moving patients out of hospital, creating new care
7 pathways for at-risk and vulnerable patients, we
8 heard a lot about that as well.

9 And at the bottom, you know, the
10 Ministry's commitment to being flexible to the OHT
11 implementation, that is really responsive to the
12 system capacity which is balanced with so many
13 teams sort of saying, this has been a crash course
14 in population health management; responding to
15 COVID is about caring for a full population, and we
16 shouldn't be slowing down our OHT activity related
17 to that.

18 However, we don't want to appropriately
19 be pulling time and resources to work if it's
20 needed locally. So we're really trying to take a
21 balanced approach to our implementation going
22 forward and building the supports that the teams
23 will need to respond appropriately to COVID but
24 also to advance their maturity overall.

25 And the last slide before the appendix

1 just emphasizes how we took some of those learnings
2 into adjusting our process overall. One of the
3 approaches we wanted to take was to be a little bit
4 less onerous in the application process, so we did
5 streamline it and emphasized through a revised
6 application, encouraging teams to engage with
7 Public Health in congregate care settings,
8 including long-term care, to really support that
9 regional response to COVID.

10 And we released some additional
11 guidance, as we spoke to you about,
12 decision-making, and have provided funding, as a
13 lot of teams were having a real challenge keeping
14 the engine going on the work that it takes to work
15 together. So really listening to that feedback and
16 building out the appropriate supports that they
17 need.

18 COMMISSIONER JACK KITTS: Can I just
19 ask a question on accountability? So I think
20 Commissioner Coke asked about accountability within
21 the teams, and so the collaborative approach.

22 So now within the teams, we have
23 hospitals that report to the Ministry of Health,
24 long-term care homes report to the Ministry of
25 Long-Term Care, many report to Ontario Health, and

1 then there's Public Health with a different
2 reporting relationship. So you've got four vested
3 interests in terms of, I guess, governance and
4 accountability.

5 Who is ultimately responsible for the
6 success or managing the Ontario Health Teams?

7 AMY OLMSTEAD: In terms of
8 responsibility for advancing Ontario Health Teams
9 and seeing them through from development and
10 implementation and maturity, that responsibility is
11 with the Ministry of Health, and we're working very
12 closely with our partners on that, including the
13 Ministry of Long-Term Care. And Ontario Health
14 does have the legislative authority at maturity to
15 be overseeing those Ontario Health Teams as well.

16 So I think what you're getting at is
17 the significant amount of work that needs to be
18 done between now and then to work with the various
19 partners in accountability to bring together a
20 shared accountability framework for the OHTs.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Does that pose a difficulty in terms of a
23 coordinated approach to have that many primary
24 partners?

25 AMY OLMSTEAD: I think it's reflective

1 of the complexity that we see in the health system
2 in Ontario and in other jurisdictions as well.

3 You know, this is the government's
4 direction with respect to Ontario Health Teams;
5 it's not just the Ministry of Health's direction.
6 So all of our partners within government and
7 accountable to government are pulling in the same
8 direction.

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Okay. Well, I don't know. Was that the end of the
11 presentation? Did I get that right?

12 AMY OLMSTEAD: Yes, that was it for our
13 slides. There are a couple of slides in the
14 appendix that I think we showed at various points
15 as well. So happy to answer other questions, or if
16 there is additional information that you'd like us
17 to provide after we leave today, that's fine as
18 well.

19 COMMISSIONER JACK KITTS: I just want
20 to clarify that from what we've heard this
21 morning -- and Allison, as you've said, we've heard
22 from others -- why we need Ontario Health Teams'
23 integrated care is quite evident to everyone. I
24 don't think there's any debate about that, that
25 that's better than the siloed system we have now.

1 What we've trying to achieve with them
2 and the quadruple aim is no argument that that's --
3 that would define any world-class health system.

4 How we're going to get there, you are
5 working extremely hard to build on the momentum and
6 learnings from the pandemic and are committed -- I
7 think I'm hearing the Ministry of Health, the
8 Ministry of Long-Term Care, Public Health, and
9 Ontario Health are all committed to getting these
10 models up and running as soon as possible and will
11 do everything they can to make that happen.

12 Is that a good summary of what we just
13 discussed in the past hour?

14 AMY OLMSTEAD: Yes, another excellent
15 summary. Yeah, exactly.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 What's your estimate of when the start-up
18 process -- if that's the correct way of referring
19 to it -- will have completed itself?

20 AMY OLMSTEAD: In terms of -- and, I
21 mean, I think we're already well into our start-up
22 process. If we're thinking of having an OHT that's
23 supporting all parts -- all people in the province,
24 again, we haven't established a timeline, but we've
25 made tremendous progress on it in just the past

1 year or so.

2 So I don't think, again, we've put any
3 timelines on. We have to be flexible with respect
4 to the pandemic and continuing to encourage the
5 local momentum and reinforcing that with the right
6 incentives on our end.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Okay. Well, unless there are any other questions?
9 I don't see -- I don't think there are. Thank you
10 very much. There's been a fair bit of discussion
11 amongst ourselves about Ontario Health Teams, and
12 not just from Commissioner Kitts but from all three
13 of us, and this has been very helpful in putting us
14 all in the picture as far as they're concerned. So
15 thank you very much.

16 AMY OLMSTEAD: Well, thank you very
17 much for your time and your questions.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 All right. Goodbye.

20 COMMISSIONER ANGELA COKE: Thank you.

21 COMMISSIONER JACK KITTS: Thank you.

22 AMY OLMSTEAD: Thank you.

23

24 -- Adjourned at 11:59 a.m.

25

1 REPORTER'S CERTIFICATE

2
3 I, OLIVIA ARNAUD, CSR, Certified
4 Shorthand Reporter, certify:

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth;

9
10 That all remarks made at the time
11 were recorded stenographically by me and were
12 thereafter transcribed;

13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.

16
17
18 Dated this 16th day of November, 2020.

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